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| **CONSENT FOR VISITATION AND OVERSIGHT** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Individual Name: | | |  | | |
| Date of Birth: | |  | | DUCK Number: |  |
| I, |  | | | | |
|  | Client/Guardian name | | | | |

Have received the following request fromSelect your agency to allow myself/my ward to be visited and spoken with, in person, by Community Support Network, Inc. (CSNI) and/or designees from one or more of the following agencies:

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| Northern Human Services, PathWays of the River Valley, Lakes Region Community Services, Community Bridges, Monadnock Developmental Services, Gateways Community Services, The Moore Center, One Sky Community Services, Community Partners, and/or Community Crossroads. |

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| --- | --- | --- |
| I understand that these visits may also include review of records held by | | Select your agency |
| as well as those held by the vendor agency that is providing services to me/my ward: | | |
| **Name of vendor/organization:** |  | |
| **Vendor agency contact *(if applicable):*** |  | |
| **Vendor Address:** |  | |
|  |  | |

I understand that these records may contain information pertaining to my/my ward’s medical and psychiatric information, substance abuse history, forensic and criminal history, and genetic testing information. I understand that this information is confidential and protected and will be used only for the purpose of enhancing safety and quality of services for individuals through coordinated monitoring of supports provided, to include review of records used during certification. I understand that this consent is valid for one year from the date signed. I understand that not consenting to these visits may mean fewer possibilities to oversee the quality of my/my ward’s services.

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| **I do** | **I do not** | Consent to oversight visits from the above designee(s). |
| **I do** | **I do not** | Consent to my/my ward’s photograph being taken for the purpose of identification. |
| **I do** | **I do not** | Consent to records being reviewed which may include my/my ward’s medical and psychiatric information, substance abuse history, forensic and criminal history, and genetic testing information |

Signed,

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| --- | --- | --- |
|  |  |  |
| Client/Guardian Signature |  | Date |
|  | |  | | --- | | *Please return form to:* | | |
| Client/Guardian Name |  |  |